The Hospital of God at Greatham

# Community Pastimes Hartlepool

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

This inspection took place on 17 and 21 February 2017 and was announced. This is the first inspection of Community Pastimes Hartlepool.

Community Pastimes Hartlepool is registered as a domiciliary care service to provide personal care for older people and younger adults. The aim of the service to enable people to access and enjoy hobbies, interests and recreational activities in the community.

At the time of the inspection there were 40 people receiving the regulated activity of personal care. The registered manager said of the regulated activity, "It's as and when required. It isn't our primary function, we provide continence care as needed and we administer meds (medicines)."

A registered manager was registered with the Care Quality Commission at the time of the inspection.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found some care records did not contain sufficient detail, one care record contained contradictions and two care records had not been updated in response following the outcome of referrals to other services such as the falls team.

The concerns we noted during the inspection had not been identified through the provider's own quality assurance systems.

You can see what action we told the provider to take at the back of the full version of the report.

Risk assessments were completed and included measures to control and minimise the risk. A operational risk assessment and business continuity plan was in place to minimise and manage any risks to the operation of the business.

Staff understood safeguarding and explained how vigilant they were to risks due to people's level of vulnerability whilst in the community.

Medicines were managed safely. Accidents and incidents were recorded and discussed within health and safety meetings for any lessons learnt.

People were supported by a small, consistent staff team who knew them and their relatives well. Staff were proactive in communicating with relatives, and in contacting external healthcare professionals if they felt

people were unwell or needed additional support.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

Relatives told us they were confident their family members were safe when being supported by staff. They felt staff treated people with respect and dignity. Staff spoke about people in a compassionate, warm and respectful manner.

A complaints policy and procedure was in place. Relatives said they knew how to complain but had not had reason to do so.

Safe recruitment practices were followed, and new staff completed a comprehensive induction before supporting people on a one to one basis.

Staff told us the training they received was comprehensive and we saw a training matrix which showed staff training was up to date. Supervision and appraisal meetings were planned for the whole year and staff said they felt well supported.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Safe staff recruitment practices were followed and there were enough staff to ensure people were supported by a consistent team who knew their needs well.

Staff understood safeguarding and explained how they constantly risk assessed and were aware of people's vulnerability.

Medicines were managed safely.

### Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to support people appropriately. They also attended regular supervision meetings and had an annual appraisal which meant their ongoing competency to support people was assessed.

Mental capacity was understood and people were supported to make their own decisions.

People were supported to access healthcare services as needed.

### Is the service caring?

Good

The service was caring.

Staff approach was positive, personal and respectful of people.

Relatives told us they, and their family member, were involved in care planning and information was shared with them appropriately.

People were treated with respect and staff had a warm, compassionate approach when speaking about people.

### Is the service responsive?

Requires Improvement

The service wasn't always responsive.

Some care plans did not provide staff with a detailed, accurate, complete and up to date record in respect of people's care and support.

Relatives told us they were very involved in their family members care and that the service was responsive to any change in need.

A complaints procedure was in place. Relatives knew how to make a complaint but said they had not had reason to do so.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

A quality assurance system was in place but it had not been effective in identifying the concerns noted within care records during the inspection.

The registered manager was aware of their responsibilities in relation to the completion of statutory notifications. They said they felt well supported by senior management in developing areas of the service.

Staff and relatives told us they thought the service was well-led and there were no improvements they could think of.

# Community Pastimes Hartlepool

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 and 21 February 2017 and was announced. We gave the registered manager 48 hours' notice of the inspection because the service is provided in the community and we needed to be sure that they would be in.

The inspection team was made up on one adult social care inspector and one expert by experience who made telephone calls to people and their relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We also contacted the local authority commissioning team and the safeguarding adult's team.

During the inspection we spoke with nine relatives and a solicitor who had acted on behalf of one of the people supported by the service. We were unable to speak to any people using the service as relatives told us they were all living with a dementia and would be unable to speak with us about their care.

We also spoke with the registered manager, one senior support worker, two support workers, the service

manager and the care services manager.

We reviewed five people's care records and three staff files including recruitment, supervision and training information.  We reviewed three medicine records, as well as records relating to the management of the service.

Good

# Is the service safe?

## Our findings

All the relatives and carers we spoke with told us they felt their family member was safe when they were with support staff. One relative said, "I have no hesitation in saying that [family member] feels safe with them I would not allow him to go out with them if I did not." Another said, "I am sure he feels safe because they have built up trust and have continuity in his care and he knows they are honest people, people he can feel at ease with and through that he feels safe." A third said, "I am sure [family member] feels safe with the staff, he's learnt to trust them through me." A fourth said, "Just knowing he is safe with his carers (staff) gives us peace of mind."

Support staff were confident that they knew how to keep people safe. One staff member said, "Yes, I've done safeguarding training. It's about awareness, having a constant eye on things to make sure people are safe, their well-being and interests are catered for. There's vulnerability even in their own home, are others taking advantage, it's about keeping people safe in all aspects of their life and trying to reduce their vulnerability." They added, "We've arranged for smoke alarms linked to the fire service to be in place and for buddy systems, we make sure people know how to use it and practice test calls. We constantly risk assess everything when we are visiting." Buddy systems are a form of assistive technology that people can use to seek help if needed. Another said, "We have a heightened awareness and keep an eye on people, make sure people are safe and have their doors locked." They added, "I even drive around the block to make sure people have gone in the house as some people like to wave us off."

We spoke with the registered manager about safeguarding. They said, "It's essential, we have a policy on medication as it's high risk, we risk assess activities, gain consent to ensure people are happy and we have a care plan policy." An adult protection policy was in place which detailed types and signs of abuse and the action staff should take if someone made a disclosure to them or if they suspected abuse. We confirmed there had been one safeguarding concern raised which had been appropriately managed.

Accidents and incidents were recorded and investigated following any event. They were then discussed within health and safety meetings. The registered manager said, "There's analysis completed in the health and safety meetings. We look at near misses, incidents, lessons learnt, preventative actions and best practice." We asked if there were any examples of any recent lessons. The registered manager was unable to recall any.

Risk assessments were completed and identified risks and control measures in relation to physical conditions, confusion, mobility, communication, behaviour, nutrition and activities. One person had a risk assessment which stated there was a medium risk in relation to eating and drinking. A choking risk was identified, but there were no control measures recorded. The risk assessment stated the person did not have any issues with food and drink consumption. We spoke to the registered manager about this who explained the person was at low risk in relation to eating and drinking and there was no choking risk. They thought the error had occurred due to the use of a generic pro forma for risk assessments.

An 'operational risk assessment and business recovery plan' was in place. This included possible risks, such

as the loss of key staff, the possible scenarios, implications and actions that could be taken if the event arose.

Relatives told us their family members generally had support from a core team of staff. One relative said, "[Family member] has a core of carers (staff), he does seem to prefer the men, probably because they know about sport but he does also get on very well with the women." Another said, "[Family member] has a few different carers (staff) but he loves them all." A third said, "We've only had a new person once and they rang me and told me, then the girl called me to go through the care plan with me." Another relative said, "I told the office I only want my [family member] to have the three (staff) she has and not to send anyone else as she knows them, they have taken that on board and only send them, they will switch (staff) around to accommodate that." One staff member said, "We have enough staff. We try to support the same people for continuity and have a rolling rota." This meant staff knew their shift pattern in advance and were able to provide support consistently to the same people.

The registered manager told us they rarely had instances of late or missed calls. Staff said they had sufficient time to travel between people's homes and visits lasted up to three hours which gave them ample time to meet people's needs.

Safe recruitment practices were followed which included an initial application form and interview. If successful at this stage references and a disclosure and barring service (DBS) check were fully completed prior to staff commencing in post. DBS checks help employers make safe decisions as they provide information about an applicant's criminal record and whether they have been barred from working with vulnerable adults and children. DBS checks were renewed every three years.

Relatives told us medicines were administered in a safe manner and were always recorded. One relative said, "[Family member] has their meds in the evening, we are not there but it is all recorded for us to see." Another relative said, "They do give his medicines and it gets recorded so we can check."

Care plans and risk assessment's included medicine management. Care plans detailed a full list of medicines taken by the person and the reasons why. There was additional information on any medicines staff supported the person with and if a relative or carer supported the person with medicines this was noted.

If people were not supported by Community Pastimes with medicines, or if people were not prescribed any medicines care plans included that staff should be observant for signs of pain or deterioration in physical well-being and report this to the persons carer, GP if appropriate and registered manager.

Medicine administration records (MAR's) were completed if people received support with the administration of medicines. A coding system was used if medicines were not taken by the person. One MAR chart had been hand written and it was noted that the staff member completing it had not signed it. This meant there was no accountability if any errors had occurred. We raised this with the management team who said they would add space for the signature, name and date of the person completing the medicine instructions on the MAR.

All staff working at Community Pastimes Hartlepool had attended recent training in the administration of medicines.

Good

# Is the service effective?

## Our findings

We looked at the support and training offered to staff. One staff said, "My induction was looking at files, policy and procedures, the company, client files. I think I spent about two weeks with different staff shadowing and meeting clients so I was a familiar face to clients and their family. We try and support the same people for continuity and have a rolling rota so that helps." One relative said, "[Family member] had a new man start recently, he shadowed for a while until my [family member] got used to him."

Staff had completed an induction and if they were new to the care sector they completed the care certificate. The Care Certificate is an identified set of standard skills, knowledge and behaviours for care staff to provide compassionate, safe and high quality care and support.

Staff confirmed they felt well trained, well supported and had regular supervision and an annual appraisal. An appraisal and supervision plan for the year was in place so staff knew when their next meeting with a line manager was. Supervision included discussions around working practice, client review, health and safety and training. Appraisal's included staff strengths, areas for development, goals, training and development, and a summary of the past year by the registered manager and the staff member.

One care worker said, "There's loads of training. Medicines, moving and handling, first aid, health and safety, infection control, food hygiene." A training matrix was in place which showed staff had attended mandatory training in areas such as medicines, safeguarding, first aid and moving and handling. A senior care worker said, "I'm currently doing my level three in health and social care with a view to lead to level four in leadership and management." They added, "I've also done training in moving and handling, safeguarding, health and safety, control of substances hazardous to health (COSHH), equality and diversity, GEM training, dementia friends and common health conditions such as mental health issues, diabetes and other physical conditions. Pretty comprehensive training is in place." The registered manager said, "All staff are trained in dementia care, it includes distressed behaviour. We attended GEMS dementia training. It was delivered to carers as well as staff." The GEMs model acknowledges that everyone's abilities can change in a moment. It works on the basis that modifying environments, situations, interactions, and expectations can create supportive positive opportunities for people living with a dementia.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive the liberty of people living in the community must be made to the Court of Protection. No applications had been made to the Court of Protection.

We spoke with relatives and people's representatives about decision making. The solicitor said, "I have power of attorney so I make the decision but they will always discuss it if we have a situation and we decide the best way forward." A relative said, "They will talk to [family member] about what he wants to do, if he wants to go out or stay in it's up to him."

The registered manager said, "Some people lack capacity, about ten people have a DoLS as they live in care homes." The authorisation procedures for depriving people of their liberty in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). They also said, "Some people in the community lack capacity based upon the care plan and social worker assessment. We have a schedule on lack of capacity. Some people have a lasting power of attorney." We asked if copies were held. The registered manager said, "No, we have knowledge of it though but don't have a copy. Family are there at a pre-assessment so we would get the detail then." A senior support worker said, "Lasting power of attorneys are predominantly for finances. We get brief overviews and follow it up at the assessment visit with families." A staff member said, "Some people have fluctuating capacity, they can make day to day decisions but more complex decisions would be made with family input or the lasting power of attorney. It's about being able to retain, and feedback the information. Some people have solicitors who work on their behalf, to act on the person's best interest."

The senior support worker said, "Some people have fluctuating capacity, dependant on the stage of dementia. No one lacks capacity. If someone did lack capacity we would look at the situation, if it involved making a risky choice to health and wellbeing and safety we would want guidance and inform safeguarding and look at a best interest decision."

When Community Pastimes Hartlepool were supporting people who resided in care homes and had an authorised DoLs in place, there were associated care plans for staff follow in relation to the support they should provide in the community.

We looked at whether people were supported to ensure any nutritional needs were met. One relative said, "If I'm going out I will leave food for him and his carer will give it to him, if he doesn't want that they will make him something else." Another relative said, "They will check that they have drinks for the night." They added, "It's all recorded so we can check." One staff member said, "It's a big part of the role to ensure nutritional intake is met, we try to go out for a bite to eat or to the supermarket for food that can accommodate people's needs. One person only has a microwave so we are always looking for things they can cook in the microwave." They added, "If people are losing weight we implement weight charts fortnightly. We know about soft diets and need, for example if someone had a stroke they might need a soft diet. It's all about approach, we know people and how to motivate them."

Staff supported people with access to relevant healthcare professionals such as speech and language therapy, occupational therapy and medical services. One relative said, "They are involved in knowing if he is unwell, this morning we both noticed he seemed unwell so the carer (staff) got a urine sample and took it to the GP." Another relative said, "They will discuss with me if he has had a bad night and keep an eye on him in case he shows signs of being unwell." A third relative said, "Recently [family member] had their meds changed and when the carer came she related to me that she seemed unwell and off her food which she knows is not like my [family member] so we decided to call the GP."

One staff member said, "Most people live with a dementia. If we go to a home and recognise a problem we feedback to the office, social worker and family to ensure the best are package is in place." Another said, "We would ring the GP (if someone was unwell), monitor, contact the community nurse, access mental health support. One person's neighbour was concerned so we had a review of the persons need."

Good

# Is the service caring?

## Our findings

Relatives told us staff were kind, caring and compassionate. Relatives also said they were very involved in their family members care and discussions around this always took place. They also felt care was personalised to meet individual need.

Relatives told us they were invited to events for carers. One relative said, "I was invited to a carer's event which I attended." Another said, "I do get invited to coffee mornings usually by phone but we also get a newsletter."

One relative said, "I just don't know what we would do without them they are all so kind and compassionate, they talk to him as a person not someone who has dementia." Another relative said, "[Family member] does not have the capacity to talk to us about his carers (staff) but we know they talk to him in kind and caring manner they say "would you like" and "how are you today", treat him as an individual." Another said, "Even though I don't see the carers (staff) much I know they are reliable, punctual, kind and caring. I know [family member] would tell me if it was any other way." A fourth relative said, "They are lovely to my [family member] and speak in a way he understands, they have lots of laughter and banter about who won the snooker." They added, "They just know him, they know how to handle his moods and they know he does not have the ability to keep score or remember the rules to snooker so they help him with that. He waits at the door for them to come. He really looks forward to them coming."

Care plans included personal information about people's life and staff clearly used this to build relationships and trust with people. The information was used to engage people in conversation and reminisce with people about their hobbies and interests. Relatives confirmed to us that staff knew people well. One relative said, "[Family member] doesn't talk much but they will encourage him to by talking about his hobbies and football, they will ask him about his team so he then responds they are very patient." Another relative said, "They will do things beyond what they have to do, like they will notice if [family member] is low on anything like tea or coffee and just bring it in with them."

One staff member said, "People are an extension of our family, we do for the client group what we would do for our own." Another said, "It's all about approach, we know people and how to motivate people, how to persuade and encourage them." They added, "People's families are really nice, we have relationships with the family as well as the person. We get to know them and how they are too and offer support. We keep them in the loop and contact all the relevant people."

Staff spoke about people in a caring and respectful manner. They were able to share people's history and current needs with us, talking to us about people's personality, their family background, current living situation as well as their needs, likes and dislikes.

Staff explained that people recognised the uniform they wore and trusted them. They explained how the registered manager had discussed changing the staff uniform but staff had felt strongly that this shouldn't happen. They recounted how many people felt reassured when they saw the uniform as they recognised it

as being staff from Community Pastimes when they may not remember staff names or faces. Staff felt this reassured people that they were safe with the staff who wore this uniform and so it had not changed.

There were many thank you cards available in the office. Comments includes, 'thank you for looking after [family member] and everything,' and '[we] were supported by a very friendly, caring and professional service. All the carers were very kind and patient.'

Requires Improvement

# Is the service responsive?

## Our findings

We looked at the assessment, planning and review of care. Pre-assessments were completed before people received any support from the service, this included meeting with the person and their family member or carer and gaining information on the person's needs such as physical health, personal preferences and requirements, behaviour and mobility. Information was also sought in relation to communication and nutrition. Some information on people's life history was recorded and included their hobbies, family and work life. Likes and dislikes were also recorded.

From the pre-assessment information care plans were developed which included information around people's health, medicines, nutrition, personal hygiene, continence, skin integrity, mobility and activities. We found some care plans, and risk assessments, lacked detail. For example, it was noted that one person did not like or tolerate children well, but there were no strategies for staff to follow should the person become distressed if around children. Another person who was living with a diagnosis of epilepsy there was differing information in relation to when to call emergency services. The care plan stated the person may require emergency services after five minutes but the risk assessment stated staff should call emergency services if the seizure persisted for longer than 30 seconds. This meant there had been a failure to consistently assess, monitor and mitigate risks relating to the health, safety and welfare of people and others who may be at risk.

Another person had been referred to the falls team but there was no follow up information recorded in relation to the outcome of this referral or any change in the persons support needs. A fourth person had been referred for a buddy system which would support them to maintain their independence in the community but there was no information as to the outcome of this referral. This meant the provider had failed to ensure accurate, complete and contemporaneous records.

Bi-monthly reviews of care plans and risk assessments were completed but there was limited detail in relation to the content of the review and most entries were recorded as 'no changes.' One entry for one person did state, 'new care plan and new risk assessment x two' but there was no detail in relation to what had prompted the new documents.

These findings were a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Relatives we spoke with told us they were very involved with their family members care plans and changes were regularly made. They told us the service were very open to suggestions and listened and were happy to work things out together. One relative said, "I speak to the office regularly, if I need to change a time they are very responsive, they will call me back, or they ring me and let me know about any issues or concerns." They added, "100% they involve us in [family members] care we spoke recently about the change in my [family members] medication, I expressed concerns and they listened took it on board and we decided to ring the GP."

Another relative said, "We discussed moving from two to four mornings. This was done through Social Services then Community Pastimes came and did a reassessment all went very smoothly." They added, "Someone will come out on a regular basis and we talk about the care plan and make any changes." Another relative said, "A senior staff member comes out and we will talk about [family members] care and how it is going and any changes will reflect in his care plan." They went on to say, "When the care was set up [registered manager] came out and introduced himself."

Another relative said, "We organised a meeting with the manager, it was a huge relief to find they could cover his needs." Another relative said, "When the care was set up initially they came to see me with the occupational therapist and did an assessment." They also said, "[Family member] has a care plan which the carers keep up to date."

The registered manager said, "Care staff now come to pre-assessments and care reviews." They added, "Care staff are really proactive, they communicate proactively, handover to each other by ringing and writing." One member of staff said, "We use the communication book to note changes and updates then we know to read the care plan. If we are in the office we will go to care reviews. If there's a change in a clients need we get the information and change it on the care plan in the house and in the office. [Registered manager] and [senior care staff] do the updates."

Review meetings were held three months after people started receiving support and then on an annual basis. Reviews included people and their relatives or carers and included health, social skills, communication, diet, and activities. People and carers were encouraged to comment on the service and feedback was positive. For example, 'Service is great, offer [person] the opportunity to access the community and get some fresh air.' Another person had commented, 'Loves the service and the staff, wouldn't know what to do without the girls visiting.' Reviews ended with a summary of how the service was meeting the person's needs.

Relatives told us they would know who to complain to but no one had any reason to. One relative said, "I would just contact the office if I had a problem they are very open." Copies of the concerns and complaints procedure was available in each person's file, alongside copies of a compliments form and a suggestions form.

A complaints log was in place. No complaints had been received by Community Pastimes but a comprehensive policy was in place which included a flow chart and a system for receiving and acting on complaints.

Requires Improvement

# Is the service well-led?

## Our findings

We spoke with the registered manager about quality assurance. They said, "We do bi-monthly file checks on all files and a monthly check of five files. The service manager does audits as does [care services manager]." The bi-monthly reviews of care plans and risk assessments were explained as being a record of what's in place, for example were documents signed. The registered manager also audited a sample of five care plans each month. This looked as whether documents were dated and signed by staff, the person and/or their carer. The registered manager said, "We are checking if documents are current and in date, and in place and signed and dated. The quality and person centred element is audited by [service manager] and [care services manager]."

The overall quality assurance process had not been effective in identifying the concerns noted during the inspection, for example the lack of detailed strategies in how to support one person who did not tolerate children well, that another person had been inappropriately identified as at risk of choking, contradictions in relation to epilepsy management for a third person, and for two further people that updates had not been added in relation to the outcome of referrals.

These findings were a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

The management team were responsive to the concerns noted and provided updated care plans and risk assessments within 48 hours of day one of the inspection.

The audits completed by the care services manager included comments from staff. A new staff member had commented, 'client documentation is clearly set out in files, person centred support is provided.' The care services manager also commented on any significant events such as notifications and safeguarding's and complaints. Three care files were reviewed on a quarterly basis. There was clear evidence that quality and completeness of information was being audited. For example they had commented, 'care plan should identify who, why, how and when to use [medicine] and what to do in the event of an emergency.' For another care record they had commented, '[person] requires the use of inhaler during the call, the direction for use in not clear, there is no consent to administer or support someone with medication during the call.' The registered manager had commented on the audits to state that all actions had been completed and new care plans and risk assessments were in place. The date actions had been completed were recorded to confirm the timeliness of the response.

Audits completed by the service manager also commented on a sample of care records, including the quality of information, for example, 'care plan needs further information to staff on how to orientate with events,' and, 'take out that wheelchair is to be sourced as he now has a new one. A risk assessment is needed.' All actions had been ticked with a note to state completed all actions but this had not been signed or dated by the person completing the actions so there was no record of timeliness and accountability. We discussed this with the management team who said they would add space to record comments, a signature, date and confirmation of actions taken.

We spoke with the registered manager about the regulated activity of personal care. They said, "It's as and when required. It isn't our primary function, we provide continence care as needed and we administer meds." The registered manager was aware of their responsibility to the Commission in relation to the submission of statutory notifications. They explained these would be completed following any deaths, misappropriation, police involvement, abuse, and changes to people's health due to a serious injury. Relevant notifications had been received by the Commission.

The registered manager told us, "[Director] visits every Friday to see how things are. We have a positive staff team, with a good skill set." They also said, "We plan to do self-audits of files as the next stage of development. I sat with [senior support worker] and redeveloped the files so they are easy to follow and it flows. Pre-assessment paperwork, care or development support plan from social worker and This is Me give a skeleton for the care plan." They told us they were very well supported. They said, "[Service manager] and [care services manager] are very supportive. I have lots of free reign. Staff observations are completed and linked to KLOEs (key lines of enquiry developed by the Commission), alongside a generic observation. We do different elements of the KLOEs each time and provide feedback at the end. It helps with appraisals and personal development."

We also spoke with them about key challenges. They said, "Awareness of legislation, changes in needs around dementia, keeping the team motivated as we need the strength at the bottom, the team is invaluable, the way they work and their commitment and effort. It's also about development to be holistic, compassionate, caring, maintain dignity and the choice of the person. You can still have a life living with dementia."

All the relatives we spoke with knew the registered manager by name, they felt it was a very open service and had regular contact. They said they felt it was organised and well run, they could not think of any changes they would make and would highly recommend the service.

One relative said, "I know [registered manager] very well we talk about everything, sometimes I go in the office for a chat." They added, "I am very, very happy with the service that Community Pastimes give. Having them means that my [family member] can live independently but have the support of her carers a couple of times a week." Another relative said, "[Registered manager] comes in to see my [family member] we talk about his care and adjust the care plan. The communication between us is very good they seem well organised."

Another relative said, "There is nothing more they could do I can only praise them, they are professional and organised, they call me if they have any concerns."

Staff were asked if there were any improvements that could be made. One staff member said, "No, we have time to travel to people, we do three hour calls so we can do everything people need, it's all satisfactory, it's really beneficial for people, we do what they want to do." They explained the best things as, "It's hugely, hugely rewarding, doing so much for people, making a difference to people's lives, people are happy to see you. We have contact one to one in care homes with people, people recognise our uniform and say, 'are you taking me out today.'" Another said, "It's a fantastic team, a great team, there's support within the team, you come in every morning and talk, we are constantly communicating about clients and have 30 minutes every morning for handover or a call on the work phone. We are a small team but supportive of each other, I couldn't fault colleagues. I could work here for the rest of my life."

One staff member said, "[Registered manager] is the best gaffer (manager) you could have. The senior is also around, they are all great, approachable, you have a laugh, and it's brilliant. We work on trust, can speak to

them, it's open, relaxed, their door is always open or they are on the end of the phone, its brilliant."

Team meetings were held monthly. One staff member said, "Team meetings are monthly. They are useful to refresh everyone on clients, it's an open conversation. There's an agenda then an open floor. We discuss any problems and how we can resolve them. It provides continuity so we can see any changes and respond to them." They added, "They are mandatory unless you are on holiday or on a call."

Quality questionnaires had been completed in 2016, with a limited response. Everyone who replied said the service was safe, effective, caring, responsive and well led. Staff were rated as 1st class and people said communication was appropriate.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure that effective systems were operated to assess, monitor, mitigate and improve the quality and safety of the services provided.<br><br>There was a failure to ensure accurate, complete and contemporaneous records in respect of each service user.<br><br>17(1); 17(2)(a)(b)(c) |